the dissected segment indicated that the process was of long duration.

Survival following an acute episode of dissecting aneurysm of the aorta is not rare. In careful perusal of the English literature since 1933, reports of 425 cases in which survival time following dissection was indicated were found. In 26 per cent of cases the survival time was more than two weeks; the longest survival, in a case reported by Cassidy and Pinniger,[3] was nine years. Development of a "chronic" dissecting aneurysm in arachnodactyly occurred in three previously reported cases.[1,2,5]

In the 13 cases of dissecting aneurysm occurring in patients with arachnodactyly, the patients were in a relatively young age group; the average age was 29 years, or approximately 20 years less than the usual age for this lesion. Hypertension, which is generally considered an important predisposing and exciting cause of dissection, was absent in most instances. Degenerative changes within the media of a type similar to those described by Erdheim were a consistent finding, and these changes appeared to be precursors of dissection. The medial lesion presumably develops during the shortened life span of the patients, for aortic disease has not been observed in autopsy studies of infants with arachnodactyly.

SUMMARY

A 32-year-old man with arachnodactyly died three months after the onset of congestive heart failure. At autopsy, an incidental healed dissecting aneurysm of the ascending aorta was noted.

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Allergic Sensitivity to Digitalis But Not to Squills

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A REVIEW OF THE LITERATURE indicates that allergic reaction to digitalis is very unusual. White,[6] noted that "allergy to foxglove is excessively rare"; and Cohen and Brodsky[2] in 1940, reviewed the scanty literature and reported a case in which urticaria and angioneurotic edema developed after the ingestion of tincture of digitalis, Digilanid® and Urginin.® Wolfe and Geiger[7] in 1953 reported upon a patient who had urticarial lesions following successive administration of digitalis leaf, digitoxin, Digoxin,® lanatoside C and Urginin. They referred to reports in the literature on digitalis eosinophilia.[3,4] Becker and Obermayer[1] made note of a type of reaction due to sensitivity to digitalis—"erythema, morbilliform or scarlatiniform." Urback and Gottlieb[5] presented an illustration of dermatitis of the forearms due to digitalis.

The following case is believed to be another example of allergic reaction to digitalis, but not to squills.

CASE REPORT

A 53-year-old housewife was first observed in April, 1951, because of shortness of breath, orthopnea and fatigue of eight months' duration. She had been aware of puffiness of the face, hands and feet for one week. There was no history of rheumatic fever. Another physician had diagnosed arterial hypertension about a year previously and had treated the patient for high blood pressure and nervousness. There was no history of allergic sensitivity to pollens, foods or drugs. The patient had one child living and well. Upon physical examination, moderate pallor of the skin was noted, and there was obvious dyspnea and orthopnea. The temperature was 98.6° F., the pulse rate 96 and the blood pressure 158/110 mm. of mercury. The peripheral veins were distended, and there was swelling of the eyelids and face, and pitting edema of the ankles and feet. Grade 3 enlargement of the heart to the left was noted, and there was a grade 4 systolic murmur at the apex which was transmitted to the left axilla and to the back. The rhythm was normal. There was dullness on percussion at both lung bases, and moist rales were heard over these areas. The edge of the liver was palpable 5 centimeters below the right costal margin and was tender.

The electrocardiographic pattern was that of left ventricular hypertrophy and anterolateral ventricular wall ischemia. Fluoroscopic examination confirmed the findings of left ventricular enlargement and pulmonary congestion. Urinalysis showed specific gravity of 1.005, pH 5.5, no albumin and no sugar, the sediment contained 30 to 50 leukocytes per high power field, and no casts.

Erythrocytes numbered 4,600,000 per cu. mm. of blood. Hemoglobin content was 14.3 gm. per 100 cc.

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and the color index was 0.91. Leukocytes numbered 7,200 per cu. mm.—74 per cent segmented, 1 per cent basophils, 20 per cent lymphocytes and 5 per cent monocytes. A stained smear appeared normal. The sedimentation rate (Wintrobe) was 8 mm. in one hour.

A diagnosis of hypertensive heart disease with congestive failure was made. Digitoxin, 1.2 mg. was given, and then a maintenance dose of 0.1 mg. daily. In addition a regimen of low salt diet and administration of ammonium chloride and mercurial diuretics was started. The only other medications received by the patient were phenobarbital and multiple vitamin capsules. (In June, 1952, Apresoline® was given, 25 mg. four times daily, in an attempt to lower the diastolic blood pressure. After a short trial this was stopped because of intractable headache.)

The response to the foregoing regimen was excellent, with relief from dyspnea and edema and a reduction of 10 pounds in body weight. Progress was satisfactory until September 8, 1952, when suddenly a generalized erythematous morbilliform rash developed. It was most intense over the right side of the thorax and the exposed areas of the arms and the V of the neck.

The patient complained of severe itching. Phenobarbital was discontinued and when the condition did not improve a dermatologist was consulted. After the usual measures did not give relief, all medication, including digitalis, was stopped and the patient was instructed to follow a low sodium diet meticulously. Corticotropin (ACTH) then was given intramuscularly, 40 mg. daily for two days, and the dermal eruption quickly cleared.

A week later digitoxin was started again, and within a matter of hours the eruption flared violently. Again the drug was stopped and the skin cleared in about a week. Following a rest period of another week a test dose of 0.5 mg. of gitalin was given by mouth. Again, within 12 hours, the rash returned. Another two weeks was spent clearing the skin, and then a single dose of Digilanid® was given and again a flaring of the erythematous morbilliform rash followed. It was then decided to try a different family of cardiotonic drugs. After another period of two weeks during which the skin again became clear, the patient was given a squill derivative, Scillaren® 0.8 mg. daily for one week, and as there was no dermal eruption the dose was increased until a full therapeutic effect was obtained. Scillaren was given thereafter and in 20 months of observation there was no return of dermatitis.

DISCUSSION

It is interesting that squills did not produce a flare-up of the patient's dermatitis even though it is closely related to digitalis glycosides. Both contain the cyclopentenophenanthrene nucleus. Cohen and Brodsky[2] and Wolfe and Geiger[7] noted that the patients they reported upon were sensitive to the squill family of cardiotonic drugs as well as to members of the digitalis family.

Of interest also is the predilection of the rash for the exposed areas of the arms and the V of the neck in this patient. Photosensitivity seems to have been a factor. No mention was made of this phenomenon in the published reports of other observers.

SUMMARY AND CONCLUSION

A case of allergic sensitivity to digitalis developing after 29 months of ingestion of digitoxin is presented. Sensitivity was manifested by a pruritic erythematous rash which was brought about also by other members of the digitalis family of drugs. When Scillaren,® a squills preparation, was given, the eruption did not occur and the patient thereafter was successfully maintained by ingestion of that drug.

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Solitary Nonparasitic Cyst of the Liver

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USUALLY, CYSTS OF THE LIVER are come upon unexpectedly during operation and pose a problem in surgical management. There are reports of approximately 200 cases of hepatic cysts in the literature, and undoubtedly many small asymptomatic cysts are never diagnosed. In 20,000 consecutive autopsies done at the Philadelphia General Hospital, Eliason and Smith[2] observed 28 cases of single cysts of the liver, none of which had been diagnosed when the patient was living.

The etiology of hepatic cysts is obscure. A commonly accepted classification is: (1) blood and degenerated cysts; (2) dermoid cysts; (3) lymphatic cysts; (4) endothelial cysts; (5) retention cysts; (6) proliferative cysts.

Dermoid and degenerated cysts are readily recognizable and are accepted as distinct entities. Cysts due to obstruction or congenital dilation of lymphatic nodes—the lymphangiomas—and endothelial cysts, which are lined with ciliated epi-

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